



State of Nevada
Department of Health and Human Services
Division of Health Care Financing and Policy

**BIENNIAL BUDGET
PRE-SESSION PRESENTATION
TO
THE LEGISLATURE**

FY 16 – FY 17

January 21, 2015

Division of Health Care Financing and Policy

Mission Statement:

To purchase and provide quality health care services to low income Nevadans in the most efficient manner; promote equal access to health care at an affordable cost to the taxpayers of Nevada; restrain the growth of health care costs; and review Medicaid and other state health care programs to maximize potential federal revenue.



Division of Health Care Financing and Policy

The Division of Health Care Financing and Policy works in partnership with the [Centers for Medicare & Medicaid Services](#) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources. Services are provided through a combination of traditional fee-for-service provider networks and managed care.

Governor's Priorities and Performance Based Budget Core Objective:

Health Services - Programs and services that help Nevadans and their communities achieve optimum lifelong health, including physical, mental, and social well-being, through prevention and access to quality, affordable healthcare.

Division of Health Care Financing and Policy

DIVISION OF HEALTH CARE
FINANCE AND POLICY

ADMINISTRATION
CARSON CITY
JAN 2015
Updates through 1-16-15

Administrator
U4610 3158 / 0001
FTE 1.0

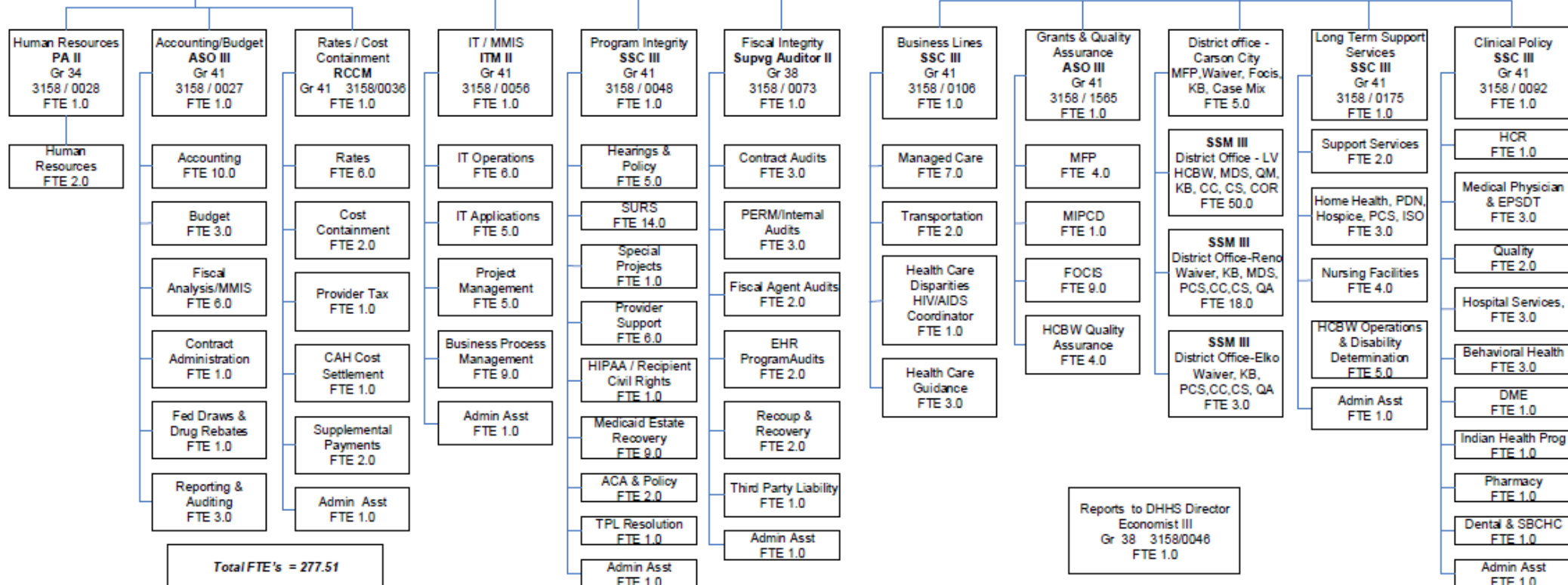
Executive Assistant
U9009 3158/0004
FTE 1.0

Admin Asst IV
Gr 29 3158 / 0043
FTE 1.0

See Administration
Support Staff
Org Chart
FTE 3.51

Deputy Administrator
Medicaid
U4612 3158/0072
FTE 1.0

ASO IV
Gr 44 3158 / 0038
FTE 1.0



Division of Health Care Financing and Policy

Activity Budgeting

- **Strategic Priorities:**

- Educated and Healthy Citizenry
- Efficient and Responsive Government

- **DHCFP Activities:**

- **Medical Services Reimbursement**

Medicaid is the largest program providing medical and health-related services to America's poorest people. Mandatory services are required as part of the federally-approved Medicaid program. This activity oversees Medicaid payments for medical services for both Fee-for-Service and those recipients in the urban area enrolled in one of the Managed Care Organization Plans.

- **Health Care Guidance Program for High Cost Fee-for-Service (FFS) Recipients**

The Health Care Guidance program provides coordination of medical and behavioral health services for targeted high cost Medicaid (FFS) recipients with chronic illnesses. These recipients are not enrolled in one of the Managed Care Organization Plans.

- **Fraud, Waste and Abuse**

This activity identifies Medicaid provider fraud, waste and abuse using staff and contractors. Providers are selected for review based upon one of the following: complaints, referrals, analysis of paid claims and/or predictive analytics. Cases suspected of fraud are referred to the Attorney General's Office. Fraud and abuse by Medicaid recipients is handled by the Welfare Division.

Division of Health Care Financing and Policy

Budget Account Summary SFY 2016-2017

BA	Budget Account Name	SFY 16				SFY 17			
		General Fund	Other Funds	Total	# of FTE	General Fund	Other Funds	Total	# of FTE
3157	Intergovernmental Transfer	-	161,455,888	161,455,888	-	-	135,869,369	135,869,369	-
3158	Medicaid Administration	27,346,696	142,054,585	169,401,281	291.51	28,903,277	149,645,836	178,549,113	291.51
3160	Increased Quality of Nursing Care	-	30,831,193	30,831,193	-	-	31,118,508	31,118,508	-
3178	Nevada Check Up	1,914,503	24,905,792	26,820,295	-	334,242	26,464,032	26,798,274	-
3243	Nevada Medicaid	537,337,946	2,520,783,462	3,058,121,408	-	602,734,423	2,557,677,131	3,160,411,554	-
TOTAL		566,599,145	2,880,030,920	3,446,630,065	291.51	631,971,942	2,900,774,876	3,532,746,818	291.51

Division of Health Care Financing and Policy

Summary of Agency Spending by Funding Source FY12-FY17

Pass through budget accounts 3157 and 3160 are not included below since it would duplicate funds that are treated like general funds.

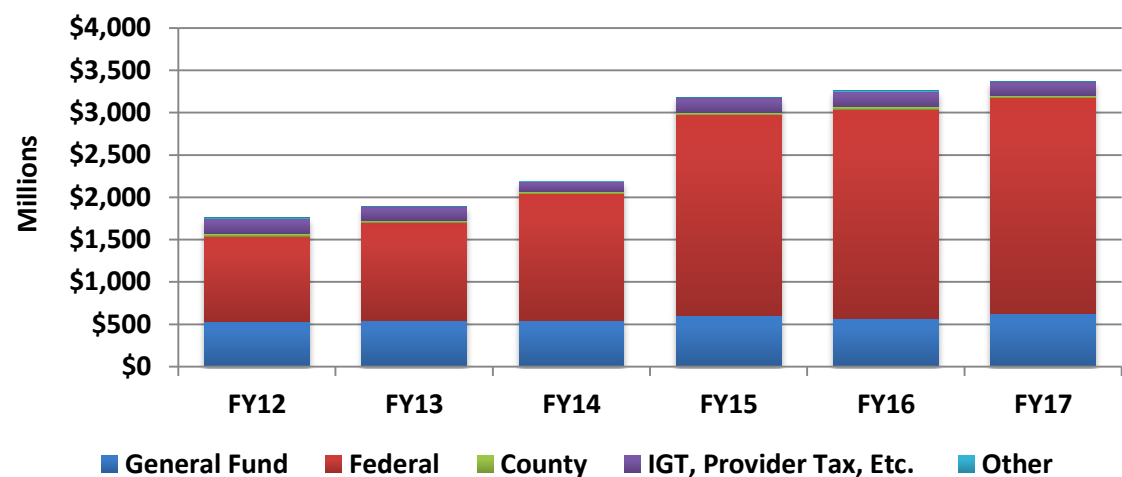
	General Fund	Federal	County	IGT, Provider Tax, Etc.	Other	Total
FY12	\$532,830,840	\$1,008,553,756	\$30,776,986	\$180,570,570	\$2,369,961	\$1,755,102,114
FY13	\$543,617,285	\$1,157,801,091	\$27,845,095	\$155,866,241	\$1,990,091	\$1,887,119,802
FY14	\$549,024,282	\$1,493,246,340	\$26,027,510	\$118,940,020	\$1,623,365	\$2,188,861,517
FY15	\$598,090,666	\$2,373,947,145	\$29,792,291	\$174,602,760	\$3,633,123	\$3,180,065,985
FY16	\$566,599,145	\$2,473,981,154	\$26,220,016	\$185,027,194	\$2,515,475	\$3,254,342,984
FY17	\$631,971,942	\$2,545,304,647	\$26,333,580	\$159,726,613	\$2,422,159	\$3,365,758,941

Note: The Funds Treated Like General Funds column includes Intergovernmental Transfers (IGT) , Provider Tax and Cost Containment Fees and Fines.

Share of Spending by Funding Source

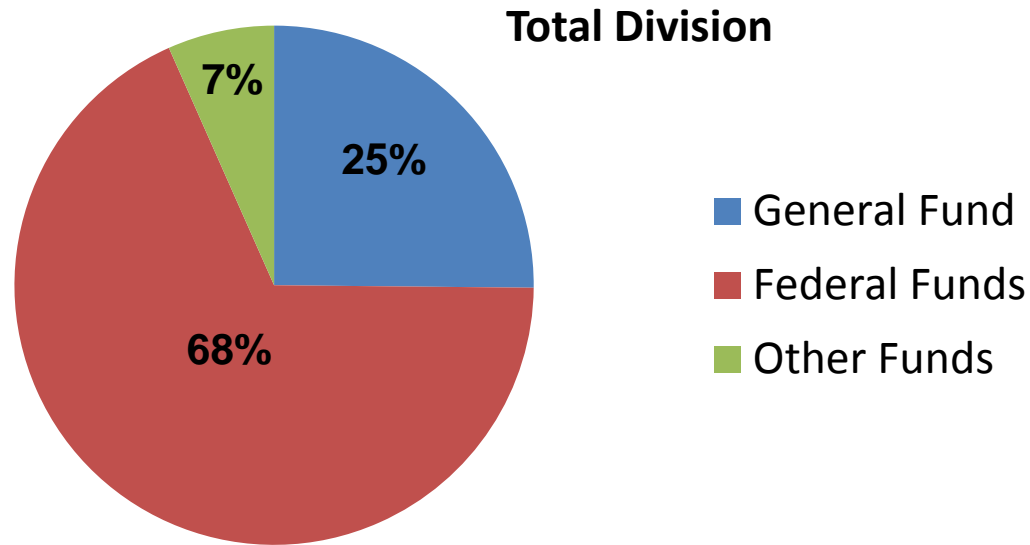
	General Fund	Federal	County	IGT, Provider Tax, Etc.	Other
FY12	30.4%	57.5%	1.8%	10.3%	0.1%
FY13	28.8%	61.4%	1.5%	8.3%	0.1%
FY14	25.1%	68.2%	1.2%	5.4%	0.1%
FY15	18.8%	74.7%	0.9%	5.5%	0.1%
FY16	17.4%	76.0%	0.8%	5.7%	0.1%
FY17	18.8%	75.6%	0.8%	4.7%	0.1%

Medicaid Medical Spending by Funding Source

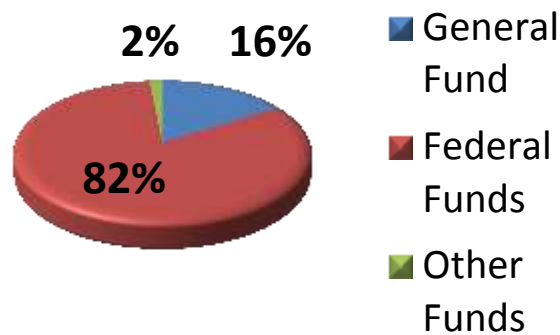


Division of Health Care Financing and Policy

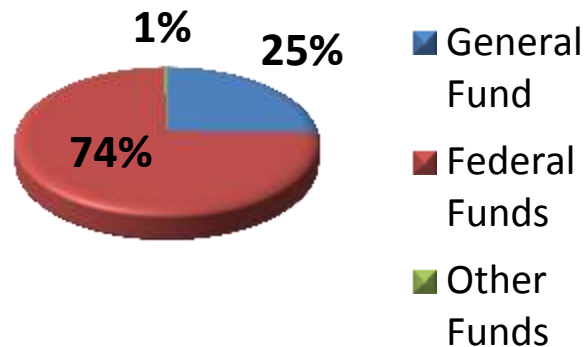
SFY 2014 Funding by Source



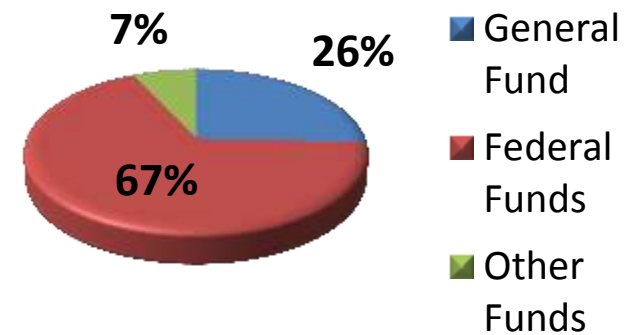
**SFY 2014 BA 3158
Administration
Total**



**SFY 2014 BA 3178
Nevada Check Up Medical
Total**



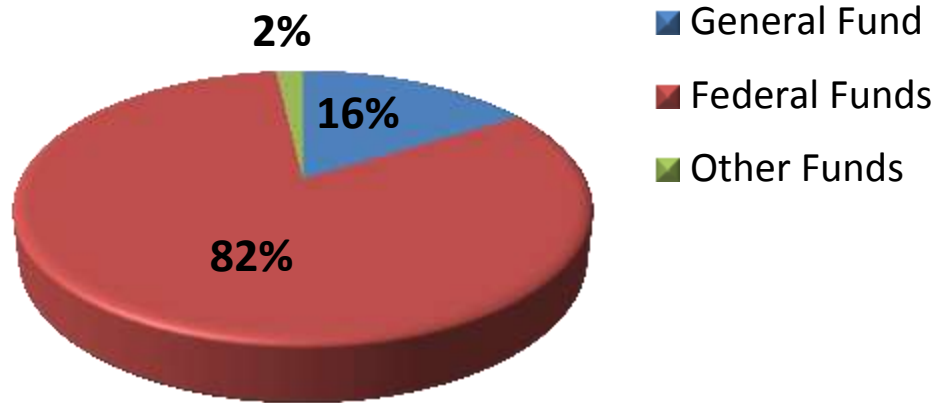
**SFY 2014 BA 3243
Medicaid Medical
Total**



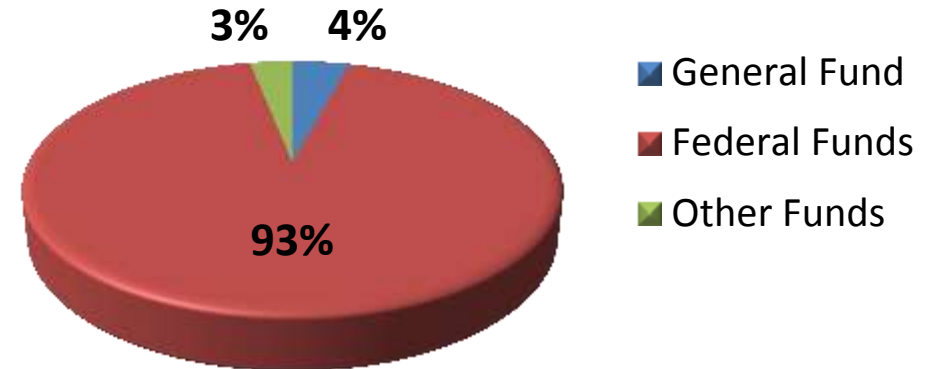
Division of Health Care Financing and Policy

G01 - SFY 2016-2017 Funding by Source

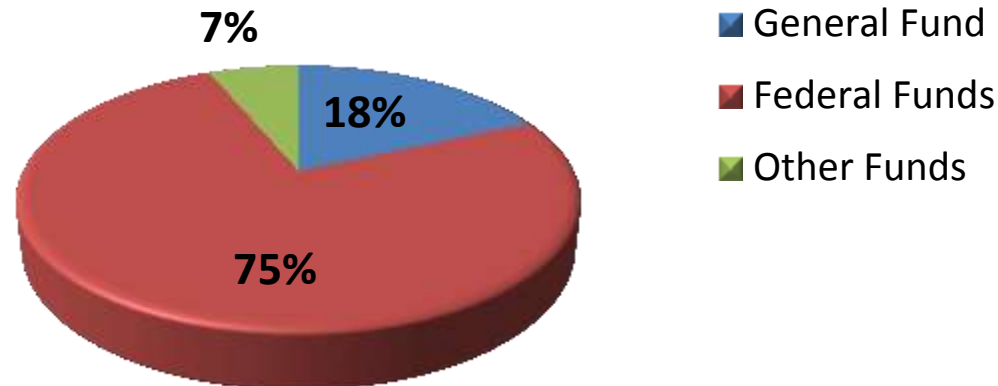
**SFY 16-17 Biennium
BA 3158 – Administration
Total by Funding**



**SFY 16-17 Biennium
BA 3178 – Nevada Check Up Medical
Total by Funding**



**SFY 16-17 Biennium
BA 3243 – Medicaid Medical
Total by Funding**



Division of Health Care Financing and Policy

Major Budget Initiative

Children with Autism Spectrum Disorder

- The Department of Health and Human Services has proposed a strategy designed to treat Autism Spectrum Disorder (ASD) through programs offered by Aging and Disability Services Division (ADSD) and Division of Healthcare Financing and Policy (DHCFP).
- ADSD houses the Autism Treatment Assistance Program (ATAP) which provides intensive behavioral treatment to children up to age 19. DHCFP will submit a state plan amendment to provide Applied Behavioral Analysis therapy for children under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
- Approximately 6,000 Nevada children have been diagnosed with Autism. ADSD reports approximately 30% are eligible for Medicaid.
- DHCFP requests funding to provide coverage for ABA services to approximately 1,800 children over the biennium, beginning in January of 2016.
- ADSD requests funding to serve an additional 264 children over the biennium, increasing the caseload to 836 children by the end of fiscal year 2017.

– ***Decision Unit M512 - Applied Behavior Analysis***

- *BA 3243 Nevada Medicaid*
 - *SFY 16 Total Cost - \$14,206,060*
 - *SFY 17 Total Cost - \$28,412,122*

<i>State General Funds - \$4,986,786</i>
<i>State General Funds - \$9,822,563</i>
- *BA 3178 Nevada Check Up*
 - *SFY 16 Total Cost - \$648,047*
 - *SFY 17 Total Cost - \$1,296,095*

<i>State General Funds - \$47,955</i>
<i>State General Funds - \$16,720</i>
- *BA 3158 DHCFP Administration*
 - *SFY 16 Total Cost - \$1,274,723*
 - *SFY 17 Total Cost - \$1,274,723*

<i>State General Funds - \$318,680</i>
<i>State General Funds - \$318,680</i>

Division of Health Care Financing and Policy

Behavioral Health Services Initiatives

- **General Acute Care Hospital Rate** - BA 3243 M150 has an increase to the reimbursement rate for inpatient psychiatric services provided by General Acute Care Hospitals. The rate increased from \$460 per day to \$944 per day effective July 1, 2014.
- **Managed Care Organization (MCO) “In Lieu of” Services**- Historically, CMS prohibited reimbursement to freestanding inpatient facilities for psychiatric services provided to recipients between the age of 22 – 64. The increase to the General Acute Care Hospital psychiatric rate (listed above) allowed DHCFP additional access to psychiatric beds and secondly, gave the ability to the MCO plans to provide inpatient psychiatric services to all ages in an alternative setting such as free standing facilities. CMS’s approval is based on the State’s ability to demonstrate that services under the MCO plan can be provided at a lower cost than the Fee-For-Service (FFS) in a General Acute Care Hospital. This is known as the “in lieu of” services and only applies to those recipients enrolled in a MCO Plan. This approval does not apply to the FFS population; however, DHCFP will continue to reimburse General Acute Care Hospitals for psychiatric services for all ages regardless if they are enrolled in MCO or FFS. Expenditures are included in the calendar year 2015 MCO monthly capitated payments.
- **Substance Abuse Expansion** - BA 3243 M150 has an increase to expand substance abuse services to be in line with the American Society of Addiction Medicine, DHCFP expanded substance abuse service coverage and added Licensed Clinical Drug and Alcohol counselors (LCDAC) and LCDAC interns as service providers.

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Provider Rate Increases for SFY 2017

- E278 Home Health Agency – Increase to reimbursement for nursing services. This will align the reimbursement for nursing services to the therapy rates within this provider class. This equates to a 17% increase to nursing services provided to children and 33% increase for nursing services provided to adults (average of 25%). DHCFP is currently experiencing access to care issues for these services. Without these services recipients could be institutionalized. Budget Account 3243.
 - *SFY 2017 Total Cost - \$8,830,028 State General Funds - \$3,000,529*
- E279 Individuals with Intellectual Disability (IID) Waiver Services – Approximately 5.7% rate increase overall for IID waiver services. Budget Account 3243. *(SGF allocated to the Aging and Disability Services Division)*
 - *SFY 2017 Federal Share - \$3,843,005 (TC amount overall \$5.9 Million)*
- E275 Inpatient Hospitals – 2.5% rate increase in the aggregate for General Acute Care Hospitals for inpatient services.
 - *SFY2017 Total Cost - \$14,419,563 State General Funds - \$4,425,776*

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Historical Perspective of Hospital Reimbursement

- General Acute Care Hospitals received an overall rate reduction of 5% in September 2008. The 5% reduction provides a savings of approximately \$30 million* in the 2016/2017 biennium.
- During the 2013 Session, SB 452 was approved which authorized the 1.5 cent Ad valorem tax collected for Indigent Accident Claims to be reallocated for implementation of a new UPL Program for inpatient hospital services. This program was implemented in December 2014 retroactively to January 1, 2014. This generates approximately \$30 million* a year in Upper Payment Limit Supplemental payments to all Nevada General Acute Care Hospitals. This program has potential to grow by millions of dollars due to the inflation of property values as well as an increase in the unmet free care assessments. The growth of this program has a negative impact to the State Net Benefit the Division receives and uses as an offset to SGF expenditures in Medicaid.
- Effective July 1, 2014, Hospitals received an increase to the per diem psychiatric/detox rate. Reimbursement was increased from \$460 to \$944. Overall estimated fiscal impact is approximately \$15.8 million* per year.
- Effective January 1, 2015, NICU Interqual level II will pay under Revenue Code 173 in the amount of \$1,487. These claims previously paid under revenue code 172 at a rate of \$312. Original estimated fiscal impact of \$7.4 million*.

**All dollars referenced are total computable amounts.*

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E277 Physician Services Rate Increase

E277 Physician, Physician Assistant (PA) & Advanced Practice Registered Nurse (APRN) – Approximately 10% overall rate increase. Budget Accounts 3243.

- *SFY 2016 Total Cost - \$37,645,658 State General Funds - \$8,869,767*
- *SFY 2017 Total Cost - \$60,169,985 State General Funds - \$14,353,366*

Comparison of current base rate methodology to proposed methodology for Physicians (PT20). PA (PT77) and APRN (PT24) pay at a lower percentage of Medicare's rate.

Services	Current Reimbursement for Base Rates % of 2002 Medicare Rates	<i>SFY 2016 Proposal</i>	<i>SFY 2017 Proposal</i>
		<i>% of 2014 Medicare Rates</i>	<i>% of 2014 Medicare Rates</i>
<i>Surgery</i>	<i>100%</i>	<i>95%</i>	<i>95%</i>
<i>Obstetrics</i>	<i>128%</i>	<i>95%</i>	<i>95%</i>
<i>Radiology</i>	<i>100%</i>	<i>90%</i>	<i>94%</i>
<i>Laboratory</i>	<i>50%</i>	<i>50%</i>	<i>50%</i>
<i>Vaccine</i>	<i>Fixed Rate</i>	<i>85%</i>	<i>85%</i>
<i>Medicine</i>	<i>85%</i>	<i>85%</i>	<i>85%</i>
<i>E&M</i>	<i>85%</i>	<i>90%</i>	<i>95%</i>

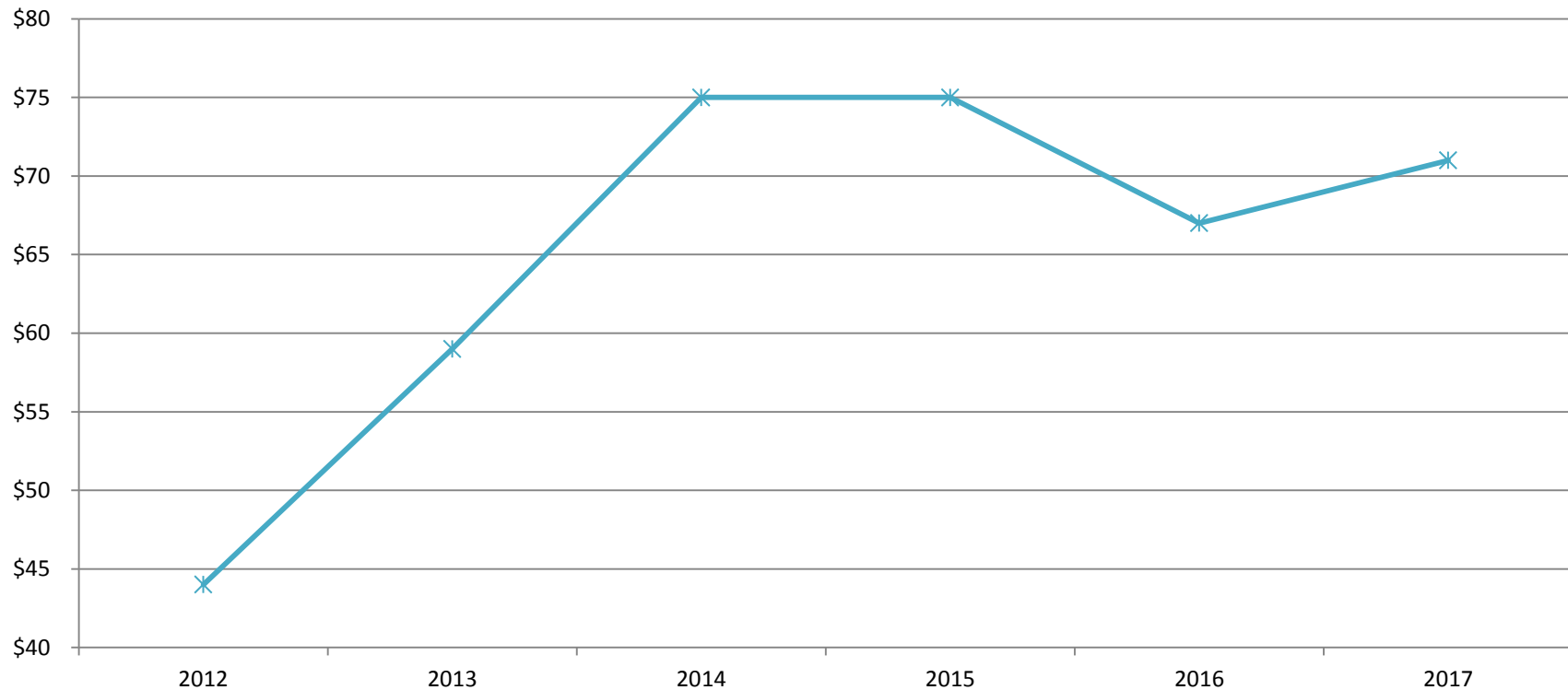
Division of Health Care Financing and Policy

E277 Physician Services Rate Increase

- The Affordable Care Act (ACA) Primary Care Physician (PCP) Supplemental payment uses Medicare's 2014 unit values/rates. Payment is made to 1,344 qualifying providers enrolled as a Physician, Physician Assistant and Advanced Practice Registered Nurse.
- DHCFP currently reimburses at a percentage of Medicare's rates using the 2002 relative unit values to calculate reimbursement of the base rates for the provider classes listed above.
- Request proposes to update the unit values for physician services to a percentage of 2014 Medicare rates. This impacts 9,359 providers enrolled under the groups listed above. Of those, approximately 2,712 provide Evaluation and Management services (primary care services are included in this code set).
- Request includes rate changes for surgery, obstetrics, radiology, laboratory, vaccine administration, medicine and evaluation and management services.
- Request has a positive impact to vaccine, medicine and the base rates for evaluation and management services. Obstetrics and surgery have a minimal overall impact that is nearly budget neutral and radiology will have an overall reduction in reimbursement.

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E277 Physician Services Rate Changes



Example of the most commonly used Primary Care Service CPT Code 99213 Office Visit - PT 20

2012 - Base Rate 85% of the 2002 Medicare Rate - \$44

2013 – 6 Months of the Base and PCP Supplemental Payment (Average) - \$59

2014 – Base Rate plus PCP Supplemental Payment 100% 2014 Medicare Rate - \$75

2015 - Base Rate plus PCP Supplemental Payment 100% 2014 Medicare Rate - \$75

2016 – Proposal is 90% of the 2014 Medicare Rate - \$67

2017 – Proposal is 95% of the 2014 Medicare Rate - \$71

The rate change will raise the base rate for primary care services while eliminating the PCP Supplemental Payment

Division of Health Care Financing and Policy

Efficiency Decision Units

- **Staff Generated Savings.**

- **Fiscal Integrity Unit Audits** – Fiscal Agent oversight and audits. The fiscal agent contract is one of the largest contracts for the Division with the exception of the Managed Care Organization Plans. It is necessary to ensure proper oversight and conduct regular audits of the fiscal agent as well as other programs within the agency.

- *Dec Unit E235* *BA 3158* *SGF 2016 (\$167,930)* *SGF 2017 (\$167,930)*

- **Program Integrity Recoveries** – Surveillance and Utilization Reviews (SURs) for Managed Care Organizations (MCO). MCO Plans are required to conduct SUR activities; however, there is little incentive for them to do so. Now that the Division has MCO encounter data, approval of additional staff will allow the Division to have proper oversight of the plans SUR requirements and to include MCO claims as part of their SUR reviews generating additional SUR collections.

- *Dec Unit E229* *BA 3243* *SGF 2016 (\$320,068)* *SGF 2017 (\$316,533)*

- **Asset Verification System (AVS):** This is a companion with DWSS for an electronic financial Asset Verification System. CMS requires states to implement a system that will identify assets that may not have been reported and reviewed when an eligibility determination is made for the Aged, Blind and Disabled Medicaid applicants.

- *Dec Unit M501* *BA 3243* *SGF 2016 \$0* *SGF 2017 (\$4,216,160)*

- **Personal Care Services (PCS) Utilization Reduction:** Reduction in utilization for PCS by 5%.

DHCFP implemented a functional assessment to new and ongoing recipients receiving PCS using a new vendor in December 2011. Due to advocate concerns, a moratorium was placed on reducing the existing service units for recipients already receiving PCS. The moratorium was lifted in August 2014. The DHCFP anticipates an overall reduction in service units authorized.

- *Dec Unit E226 BA 3243* *SGF 2016 (\$1,475,045)* *SGF 2017 (\$1,471,008)*

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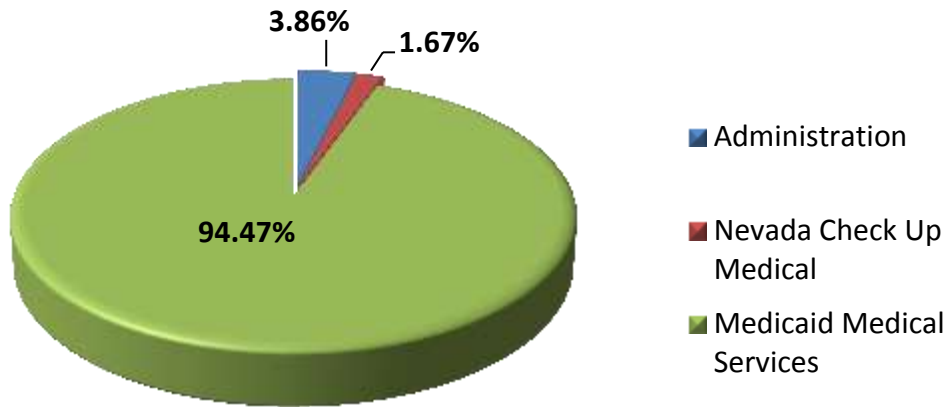
Efficiency Decision Units Continued

- **Health Care Guidance Program for High Cost Fee-For-Service (FFS) Recipients:** This program was approved under an 1115 demonstration waiver and implemented in June 2014. It is anticipated that expenditures for these high cost recipients under the Fee-For-Service Program will reduce by 5% as a result of their care being managed and coordinated. Programs of this nature will take time for results and outcomes to be realized.
 - *Dec Unit E227 BA 3243* *SGF 2016 (\$6,502,906)* *SGF 2017 (\$6,769,070)*
- **Basic Skills Training (BST) Utilization Reduction:** Reduction in expenditures for BST due to recent changes in the review of prior authorizations for these services. These services are under the rehabilitation authority and must be medically necessary as well as meet all other rehabilitation criteria. Other BST savings are realized as an offset through the Applied Behavioral Analysis initiative.
 - *Dec Unit E232 BA 3243* *SGF 2016 (\$4,712,090)* *SGF 2017 (\$4,712,632)*
- **Managed Care Organization/Third Party Liability (TPL):** Managed Care Organizations are required to identify and pursue TPL for recipients and to collect any credit balance providers may have as a result of multiple payers. There is little incentive for the MCOs plans to aggressively pursue these recoveries; therefore, DHCFP is pursuing any TPL and credit balances that remain after a 12 month period for MCO enrollees. Both initiatives are currently being pursued for the FFS population.
 - *Dec Unit E231 BA 3243* *SGF 2016 (1,978,526)* *SGF 2017 (\$2,123,368)*

Division of Health Care Financing and Policy

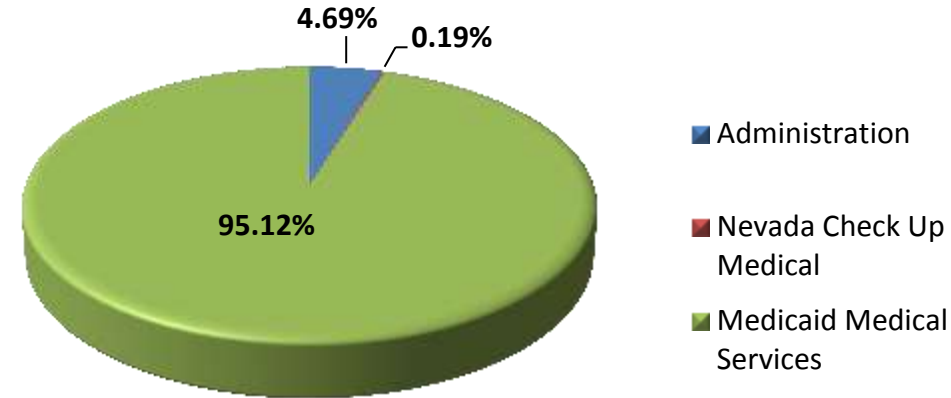
General Funds by Budget Account 2014-15 & 2016-17 Biennia

**Legislative Approved General Funds
2014-2015 Biennium**



\$1,103,335,240

**Gov Rec General Funds
2016-2017 Biennium**



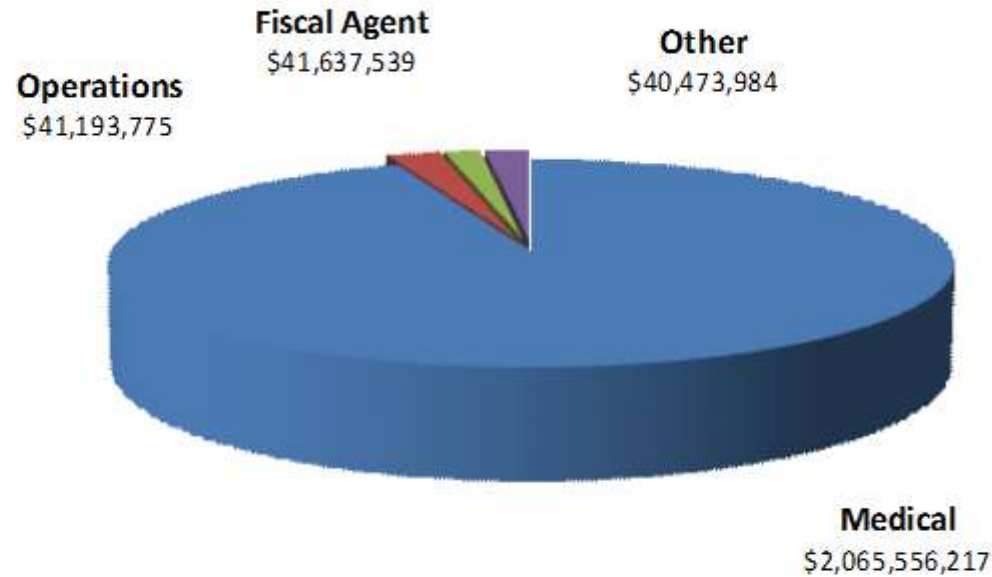
\$1,198,571,087

Change From 2014 - 2015 Biennium	
Expenditure Type	General Fund
Caseload (M200s)	\$136,482,270
Mandates (M500s)	(\$2,803,913)
Rates	\$27,522,866
MBI - Expanded Services (ABA)	\$15,511,384
New Staff (Not Caseload or Mandate)	(\$356,111)
TIRs (E550s)	\$3,349,452
Efficiency	(\$29,744,645)
Other	\$24,268,432
Total Dec Units minus Base	\$174,229,735
FMAP Savings	(\$78,993,888)
Change from 2014 - 2015 Biennium	\$95,235,847

Division of Health Care Financing and Policy

Medicaid/Nevada Check Up Medical & Administration Expenditures

SFY 2014



Total Computable Spend: \$2,188,861,515

	SFY 2014	
Medical (Medicaid and Nevada Check Up)	\$2,065,556,217	94.37%
DHCFP Operations	\$41,193,775	1.88%
DHCFP Fiscal Agent	\$41,637,539	1.90%
Public and Behavioral Health	\$1,155,117	0.05%
Division of Welfare and Supportive Services	\$31,816,115	1.45%
Division of Aging Admin	\$5,571,097	0.25%
Local Governments/Administrative Claiming	\$1,035,185	0.05%
Division of Child and Family Services	\$704,954	0.03%
Health Insurance Exchange	\$68,503	0.00%
Directors Office	\$90,450	0.00%
Department of Administration	\$10,813	0.00%
Transfer to Legislative Council Bureau	\$21,750	0.00%
TOTAL	\$2,188,861,515	100.00%

ADMIN OTHER
\$40,473,984
(Majority of these
funds are pass
through of federal
dollars to sister &
state agencies for
Admin services)

Division of Health Care Financing and Policy

MMIS Replacement BA 3158

Decision Unit E550 – Technology Investment Request (TIR)

Purpose

Phase III of Three Phase Medicaid Management Information System (MMIS) Replacement Project *

- Phase I, Study – MITA State Self-Assessment (approved by 2007 Legislature, completed in 2009)
- Phase II, Planning – Requirements Gathering & Validation/Preparation of Phase III Documents such as TIR, Advanced Planning Documents & RFP (approved by the 2013 Legislature, completed in 2015)
- **Phase III**, Release RFP(s), evaluate proposal(s) and negotiate and award contract(s); conduct design and development of automated solutions; begin implementation of MITA aligned solution(s) compliant with CMS certification criteria

**Final deployment and CMS certification will not occur until SFY19*

Estimated Costs Total Computable – Funding is a 90/10 split with 10% SGF

SFY16 \$13,533,409

SFY17 \$19,961,110

Division of Health Care Financing and Policy

Staff Proposals - Mandatory

- **Medicaid Administration – Budget Account 3158**

- **Mandatory Positions (31 FTE's)**

- M501 – Requests 2 Long Term Support Services (LTSS) WIN Waiver Staff: Case Manage the addition of 51 new slots for the Home and Community Based Waiver for Persons with Physical Disabilities (WIN). Staff will be transferred to ADSD in E901.
 - M502 – Requests 7 Program Integrity Staff: New SURs, Hearings, Program Integrity, and HIPAA staff necessary in order to keep up with current workload and address the backlog of surveillance and utilization reviews of medical claims. ***Associated savings in BA 3243.***
 - M503 – Request 6 District Office Staff: Meet the customer service and care coordination needs of the rapidly increasing Medicaid enrollment due to the Affordable Care Act and the newly-eligible Medicaid recipients.
 - M504 – Requests 2 Rates & Cost Containment Staff: Accommodate increases in workload for new Upper Payment Limit (UPL) Supplemental Payment Programs and newly required UPL demonstrations and reoccurring provider rate reviews as a result of health care reform.
 - M505 – Requests 1 Accounting & Budget Staff: Track and analyze Affordable Care Act (ACA) related expenditures and ensure compliance with ACA reporting requirements.
 - M506 – Requests 3 IT Staff: Support increased workload due to the ACA Medicaid Expansion and the future Design Development and Implementation (DDI) phase of the Medicaid Management Information System (MMIS) replacement project.
 - M507 – Requests 8 - 1915(i) Staff: Ensure compliance with new federal rules related to the 1915(i) State Plan Home and Community Based Services.
 - M511 – Requests 2 Applied Behavioral Analysis staff: Develop and maintain the Agency's behavioral intervention policy in compliance with the Centers for Medicare and Medicaid (CM) regulations.

- *SFY 2016 Total Cost \$1,616,212*

- State General Funds \$784,054*

- *SFY 2017 Total Cost \$1,999,086*

- State General Funds \$966,906*

Division of Health Care Financing and Policy

Staff Proposals - Enhancements

- **Medicaid Administration – BA 3158/Savings in BA 3158 and 3243**

- **Enhancement Positions (10 FTE's)**

- E226 – Requests 1 Clinical Policy Staff: Contract oversight for utilization management and review of best practice delivery systems.
 - E227 – Requests 2 IT Staff: Provide advanced technical skills to support the changes proposed in the fiscal agent system and internal system requirements.
 - E229 – Requests 4 Program Integrity Staff: Identify provider fraud, waste and abuse including Managed Care Claims.

Associated savings - E229 BA 3243 - SGF 2016 (\$320,068) /SGF 2017 (\$316,533)

- E230 – Requests 3 Fiscal Integrity Staff: Fiscal agent oversight, ensure proper claim data adjustments, and comply with new audit requirements.

Associated Savings - E235 BA 3158 - SGF 2016 (\$167,930)/SGF 2017 (\$167,930)

- *SFY 2016 Total Cost (\$1,110,744)* *State General Funds (\$212,120)*

- *SFY 2017 Total Cost (\$975,028)* *State General Funds (\$143,991)*

Division of Health Care Financing and Policy

FTE Summary

3158 DHCFP Administration - G01

		FY 14	FY 15	FY 16	FY 17
Base		277.51	277.51	277.51	277.51
M501 Long Term Support Services Staff	HCC II (1), HCC II-RN (1)			2	2
M502 Program Integrity Staff	AA II (1), MA II (3), MA III (2), SSPS II (1)			7	7
M503 District Office Staff	AA III (3), HCC II (3)			6	6
M504 Rates and Cost Containment Staff	Management Analyst III (2)			2	2
M505 Accounting and Budget Staff	Management Analyst II (1)			1	1
M506 Business Process Management Unit Staff	BPA I (2), BPA II (1)			3	3
M507 1915(i) Staff	HCC II (6), SSPS II (2)			8	8
M511 Applied Behavior Analysis Staff	Social Services Program Specialist II (2)			2	2
E226 Clinical Policy Staff	HRA III (1)			1	1
E227 Information Services Staff	ITP III (2)			2	2
E229 Program Integrity Staff	MA II (3), MA IV (1)			4	4
E230 Fiscal Integrity Staff	MA II (2), Auditor II (1)			3	3
E900 WIN Waiver Staff to Aging	AA II (1), AA III (1), HCC II (16), HCC III (1), HCC II-RN (2), HCC III-RN (1), HCC IV (3)			-25	-25
E901 WIN Waiver Staff to Aging	HCC II (1), HCC II-RN (1)			-2	-2

Division of Healthcare Financing and Policy Totals	277.51	277.51	291.51	291.51
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Division of Health Care Financing and Policy

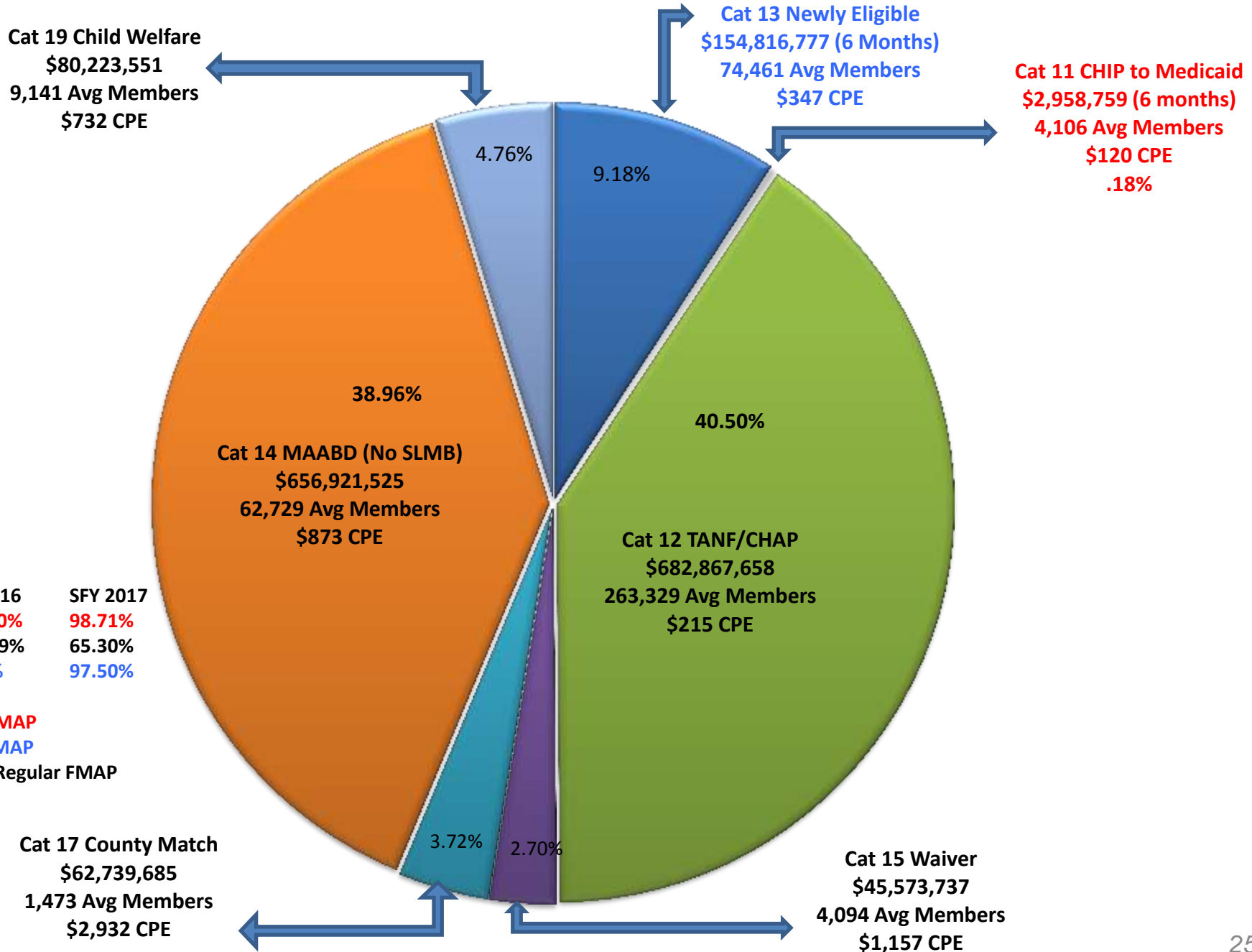
Staff Transfer to Aging and Disability Services

- The Division of Aging and Disability Services operates two of the three Home and Community Based Waiver Programs. This request will transfer existing and newly requested case management staff for the WIN Waiver to ensure consistency within the three waiver programs.
- **E900 – Transfer 25 existing FTE’s**
 - SFY 2016 Total Cost (\$1,912,378) State General Funds (\$974,369)
 - SFY 2017 Total Cost (\$1,949,136) State General Funds (\$956,031)
- **E901 – Transfer 2 new FTE’s from M501**
 - SFY 2016 Total Cost (\$111,377) State General Funds (\$55,688)
 - SFY 2017 Total Cost (\$139,053) State General Funds (\$69,526)

Division of Health Care Financing and Policy

2014 Medicaid Cost by Budget Category Budget Account 3243

Average Members per Month and Average Monthly Cost Per Eligible (CPE)



Division of Health Care Financing and Policy

Medicaid Caseload Growth

- **Medicaid Medical – BA 3243**

- Normal Caseload Growth

- M200 – Caseload is projected to increase from 520,648 at the end of fiscal year 2014 to 565,244 at the end of fiscal year 2017, an increase of 44,596 (8.57 percent).

- *SFY 2015 Caseload Increase – 51.42%*
 - *SFY 2016 Caseload Increase – (0.83%)*
 - *SFY 2017 Caseload Increase – (0.11%)*
 - *SFY 16 Total Cost - \$632,698,431 State General Funds - \$49,884,298*
 - *SFY 17 Total Cost - \$674,035,508 State General Funds - \$82,154,805*

- Waiver Caseload Growth 317 New Slots

- M201 – 51 WIN slots (*111 on waitlist as of August 2014*)

- *7.87% Caseload Increase for the WIN Waiver over SFY 2014*
 - *SFY 16 Total Cost - \$220,374 State General Funds - \$77,594*
 - *SFY 17 Total Cost - \$559,680 State General Funds - \$194,209*

- M202 - 93 IID slots (*680 on waitlist as of August 2014*)

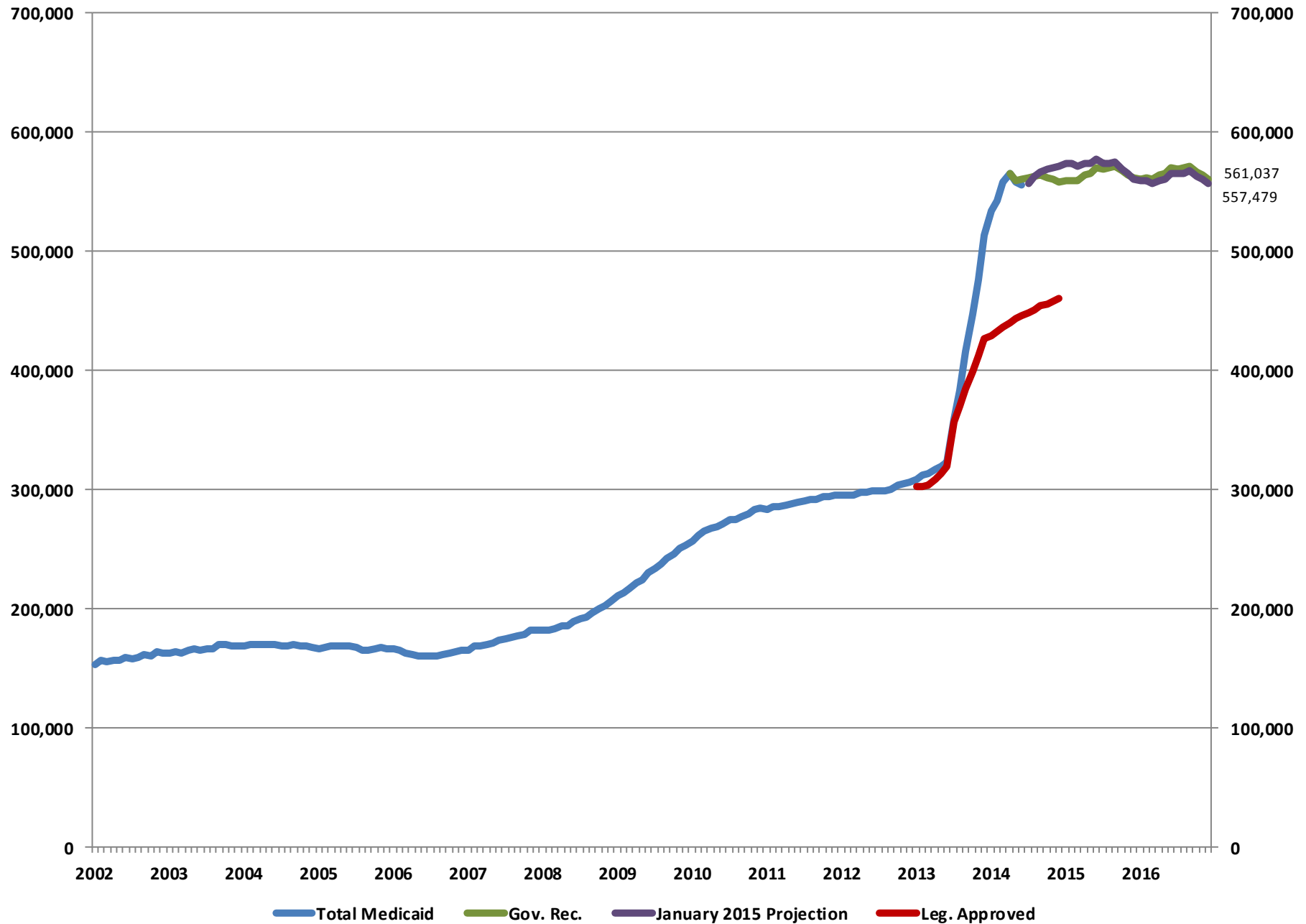
- *5.14% Caseload Increase for the IID Waiver over SFY 2014*
 - *SFY 16 Total Cost - \$222,261 State General Funds - \$27,761*
 - *SFY 17 Total Cost - \$1,301,040 State General Funds - \$160,147*

- M203 – 173 HCBW slots (*513 on waitlist as of August 2014*)

- *9.88% Caseload Increase for the HCBW waiver over SFY 2014*
 - *SFY 16 Total Cost - \$694,935 State General Funds - \$244,686*
 - *SFY 17 Total Cost - \$1,881,925 State General Funds - \$653,029*

Division of Health Care Financing and Policy

Total Medicaid Recipients



Note: This chart was created for DWSS staffing purposes and includes DWSS waiver caseload counts. For this reason, the total caseload differs slightly from that used by DHCFP for the budget.

Division of Health Care Financing and Policy

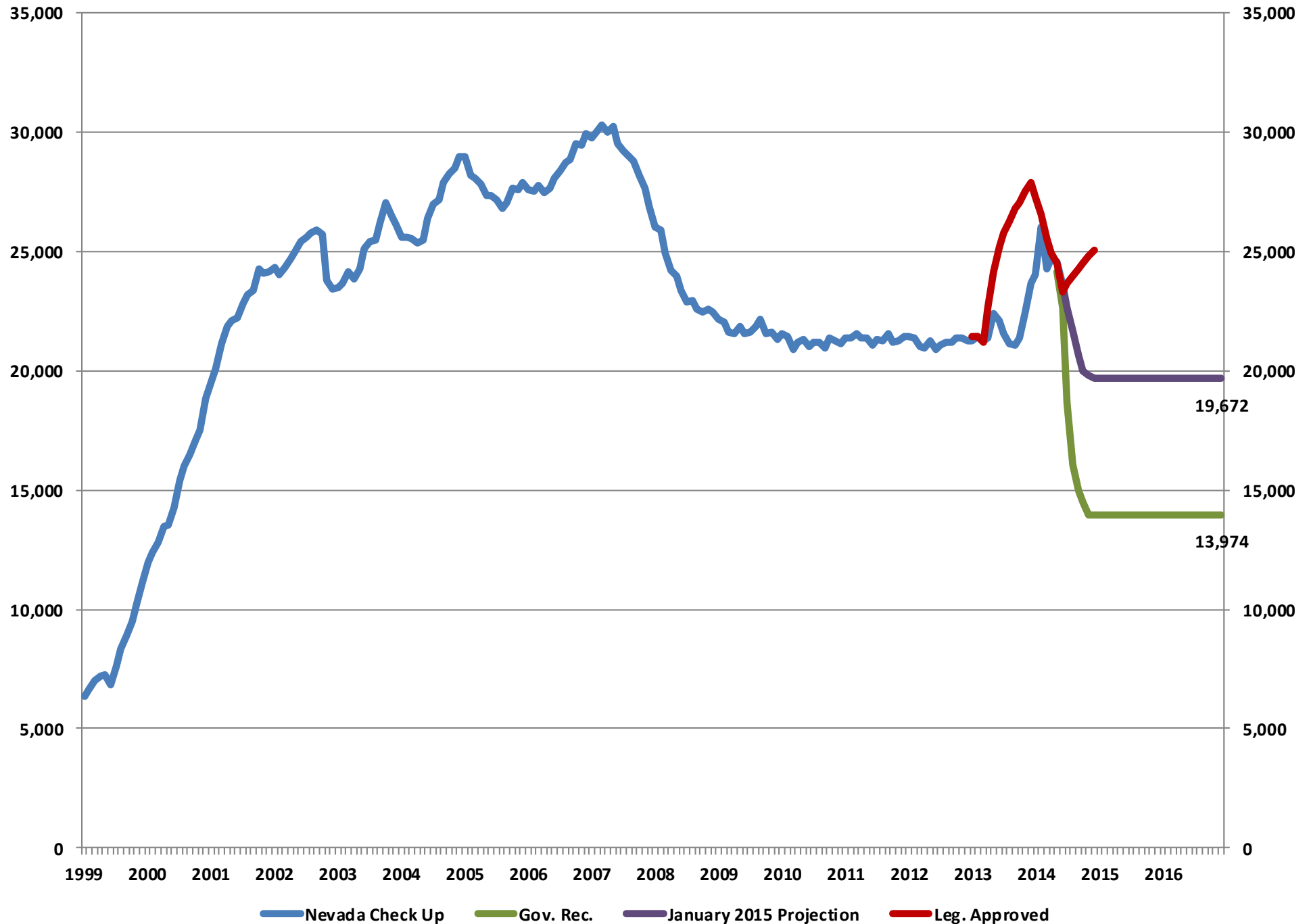
Nevada Check Up

- **Nevada Check Up – BA 3178**
 - **Normal Caseload Growth**
 - M200 – Caseload is projected to decrease from 23,655 end of fiscal year 2014 to 13,974 at the end of fiscal year 2017, a decrease of 9,681 (40.93 percent).
 - *SFY 16 Total Cost – (\$12,673,753) State General Funds - (\$892,507)*
 - *SFY 17 Total Cost – (\$12,553,719) State General Funds - (\$154,039)*
 - **Nevada Check Funding:**
 - **CHIP Funding is pending re-authorization by Congress**
 - If not re-authorized grants will not be awarded beyond FFY 2015.
 - States have a year run out period to use the FFY 2015 award.
 - Currently drawing from the FFY 2014 grant award; projections show enough funding in the FFY 2015 grant to cover the program through FFY 2016 (September 30, 2016).
 - There is a maintenance of effort requirement through FFY 2019; recipients would need to be moved to the Medicaid program increasing the Federal Poverty Level rate to 200% for children through FFY 2019.
 - Budget uses the blended ACA Enhanced FMAP which is 23% over the normal CHIP Enhanced FMAP:

– ACA Enhanced FMAP	SFY 2016 – 92.60%	SFY 2017 – 98.71%
– Enhanced FMAP	SFY 2016 - 75.35%	SFY 2017 - 75.71%
 - The ACA Enhanced FMAP also applies to Medicaid Budget Account 3243 Cat 11 and CHIP administrative expenditures in Budget Account 3158.

Division of Health Care Financing and Policy

Nevada Check Up Caseload



Division of Health Care Financing and Policy

BA 3157 – Inter-Governmental Transfer

BA 3157 – Intergovernmental Transfer (IGT)

- Voluntary Contribution percentage remains at 50% of Total Computable costs for Clark County in the SFY 16 – 17 Biennium. Programs that have a State Net Benefit (SNB) are GME and the Public UPL In-patient and Out-patient Programs.
- DSH has a different State Net Benefit rate that is not voluntary since it is mandated in NRS. The IGT is paid at approximately 70% of the total DSH payments.
- Other programs/services that are funded with IGT passed through BA 3157 with no State Net Benefit are; Regional Transportation Commission for non-emergency transportation, UNSOM Supplemental Payments for Mental Health Services, School Based Services, Private Collaborative UPL and the Indigent Accident Fund (IAF) UPL.
- Reserves – There are two reserves that are anticipated to continue through the biennium. County Match set aside in the amount of \$2 million and IAF reserve of \$5.2 million.
- The Budget includes an anticipated balance forward amount from SFY 2015 to SFY 2016 of \$18 .1 million. The amount is budgeted to offset SGF in BA 3243 – Medicaid for the Aged, Blind and Disabled medical expenditures.
- Total State Net Benefit Budgeted for the biennium:
 - SFY 2016 - \$43,221,692
 - SFY 2017 - \$41,570,714
 - ***(SFY 2014 Base - State Net Benefit \$34.6 million)***

Division of Health Care Financing and Policy

BA 3157 – Inter-Governmental Transfer

	SFY 16						SFY 17					
Programs with a State Net Benefit (SNB)	Total Sup Pymnt	Federal Share	IGT & 1 cent Sup IAF for DSH offset	State Share	*State Net Benefit	**Hospital Net Benefit	Total Pymnt	Federal Share	IGT & 1 cent Sup IAF for DSH offset	State Share	*State Net Benefit	**Hospital Net Benefit
UPL - Public O/P****	11,721,328	7,594,248	6,228,223	4,127,080	2,101,143	5,493,105	14,032,252	9,163,061	7,494,346	4,869,191	2,625,155	6,537,906
UPL - Public I/P***	80,598,254	52,219,609	40,097,549	28,378,645	11,718,904	40,500,705	67,043,508	43,779,411	33,348,295	23,264,097	10,084,198	33,695,213
GME - UMC only	11,950,287	7,742,591	5,975,144	4,207,696	1,767,447	5,975,144	13,071,491	8,535,684	6,535,746	4,535,807	1,999,938	6,535,746
DSH	78,410,431	50,802,118	55,242,510	27,608,313	27,634,197	23,167,921	75,052,874	49,009,527	52,904,771	26,043,347	26,861,424	22,148,103
Total	182,680,300	118,358,566	107,543,426	64,321,734	43,221,692	75,136,875	169,200,125	110,487,682	100,283,158	58,712,443	41,570,714	68,916,968

	SFY 16						SFY 17					
Other Programs/ Services Pd w/IGT no SNB	Total Sup Pymnt	Federal Share	IGT	State Share	*State Net Benefit	**Provider Net Benefit	Total Pymnt	Federal Share	IGT	State Share	*State Net Benefit	**Provider Net Benefit
RTC Non-ER Trans	7,988,521	5,175,763	2,812,758	2,812,758	0	5,175,763	7,803,491	5,095,680	2,707,811	2,707,811	0	5,095,680
UNSOM *****	4,961,203	3,214,363	1,746,840	1,746,840	0	3,214,363	5,546,625	3,621,946	1,924,679	1,924,679	0	3,621,946
School Based Svcs	15,893,637	10,297,487	5,596,150	5,596,150	0	10,297,487	15,858,437	10,355,559	5,502,878	5,502,878	0	10,355,559
Private UPL *****	4,578,001	2,966,087	1,611,914	1,611,914	0	2,966,087	4,378,000	2,858,834	1,519,166	1,519,166	0	2,858,834
IAF UPL	31,938,915	20,693,223	11,245,692	11,245,692	0	20,693,223	32,408,334	21,162,642	11,245,692	11,245,692	0	21,162,642
	65,360,277	42,346,923	23,013,354	23,013,354	0	42,346,923	65,994,887	43,094,661	22,900,226	22,900,226	0	43,094,661

Grand Total	248,040,577	160,705,490	130,556,779	87,335,087	43,221,692	117,483,798	235,195,012	153,582,343	123,183,383	81,612,669	41,570,714	112,011,629
UMC/Clark County Only												
	SFY 16						SFY 17					
UMC Hospital	Total Pymnt to UMC	Federal Share	UMC IGT	State Share	*State Net Benefit	**UMC Hospital Net Benefit	Total Pymnt to UMC	Federal Share	UMC IGT	State Share	*State Net Benefit	**UMC Hospital Net Benefit
UPL - Public O/P	8,045,634	5,212,766	4,022,817	2,832,868	1,189,949	4,022,817	9,250,053	6,040,285	4,625,027	3,209,768	1,415,258	4,625,027
GME	11,950,287	7,742,591	5,975,144	4,207,696	1,767,447	5,975,144	13,071,491	8,535,684	6,535,746	4,535,807	1,999,938	6,535,746
UPL - Public I/P	79,235,317	51,336,562	39,617,659	27,898,755	11,718,903	39,617,659	65,909,788	43,039,092	32,954,894	22,870,696	10,084,198	32,954,894
DSH	68,977,656	44,690,623	46,356,609	24,287,033	22,069,576	22,621,047	66,024,013	43,113,680	44,055,339	22,910,333	21,145,006	21,968,674
UMC Sub Total	168,208,894	108,982,542	95,972,228	59,226,352	36,745,876	72,236,666	154,255,345	100,728,740	88,171,005	53,526,605	34,644,400	66,084,340

* State Net Benefit is IGT minus State Share.
 ** Hospital Net Benefit is Total Payment minus IGT.
 *** Only Clark County pays SNB for In-Patient UPL
 ****Clark County pays 50% SNB all others pay 60% SNB for Out-Patient UPL
 *****UNSOM \$50,000 IGT Per Year for DHCFF Admin Services
 *****Private UPL SNB goes to DHHS not DHCFF

Division of Health Care Financing and Policy

BA 3160 – Increased Quality of Nursing Care

- **BA 3160 – Increased Quality of Nursing Care**
 - SFY 2016
 - Projected Provider Tax – \$29,928,628
 - Projected Total Computable Supplemental Payment - \$84,157,647
 - SFY 2017
 - Projected Provider Tax – \$30,215,942
 - Projected Total Computable Supplemental Payment - \$86,214,263

Providers are currently taxed at the maximum allowable rate of 6%.
1% of taxes collected transfer to BA 3158 for administrative services.

Division of Health Care Financing and Policy

Supplemental Appropriation BA 3243 Medicaid Medical

	Supplemental Appropriation				
	Total	2501	3501	3511	Other
2501 SGF Appropriation	527,872	527,872			
3501 Title XXI	(14,505,738)		(14,505,738)		
3511 Title XIX	(26,232,826)			(26,232,826)	
4750 Transfer from IGT	(19,645,301)				(19,645,301)
	(59,855,993)	527,872	(14,505,738)	(26,232,826)	(19,645,301)
11-CHIP to Medicaid	(18,879,566)	(4,373,828)	(14,505,738)	0	0
12 - TANF/CHAP	20,349,857	17,679,345		2,670,512	0
14 - MAABD	25,481,990	7,873,086		27,316,214	(9,707,310)
15 - Waiver	4,326,264	1,471,441		2,854,823	0
17-County Match	(14,929,549)	(668,357)		(9,466,279)	(4,794,913)
18-Sister Agency Med Pay	0	(147,933)		201,662	(53,729)
19 - Child Welfare	1,557,986	736,922		821,064	0
28 - Offline	(77,762,975)	(22,042,804)		(50,630,822)	(5,089,349)
	(59,855,993)	527,872	(14,505,738)	(26,232,826)	(19,645,301)

Division of Health Care Financing and Policy

BDR Summary

Non - Budget BDR Summary

BDR#	DOA#	DHHS#	Division	NRS	Description	Impact
38-327 (AB41)			Health Care Financing & Policy	NRS 428.205 NRS 428.207 NRS 428.305 NRS 428.470 NRS 428.480 NRS 428.490	Revise NRS 428 to remove the requirement of the board, and allows the agency to balance forward any remaining funds not used.	
57-326 (AB87)			Health Care Financing & Policy	NRS 689A.430 NRS 689B.300	Revise NRS 689A & 689B to identify all possibly commercial insurance payers by business type.	
38-325 (SB14)			Health Care Financing & Policy	NRS 422.4035	Revise NRS 422.4035 to decrease minimum number of committee members and clarify requirements.	

Budget BDR Summary

BDR#	DOA#	DHHS#	Division	NRS	Description	Impact
Not Issued Yet			Health Care Financing & Policy	422.4025	Revise NRS 422.4025 to eliminate sunset/expiration date.	Associated Dec Unit E225 in BA 3243 if BDR is not approved.

Division of Health Care Financing and Policy

Division Challenges

Access to Care

- Implementation of Telehealth Expansion
- Advanced Practice Registered Nurses
- Physician Forums with FFS and MCO
- Prior Authorization Alignment between FFS and MCO
- Health Care Guidance Program for high need Fee for Service Recipients
- Increased Inpatient Psychiatric Rate
- Implemented “In Lieu of” service option for MCO
- Completing access to care analysis and implementing a secret shopper
- Requesting provider rate increases

Division of Health Care Financing and Policy

Additional Division Challenges

- **Nevada Check Up Re-Authorization Uncertainty**
- **Improvement for Program Management**
 - TIR to replace outdated MMIS and peripheral system(s).
 - Need additional staff to handle current workload due to Medicaid expansion to ensure proper oversight of programs.

Division of Health Care Financing and Policy

Questions?

